



TAKE TIME

One theme that regularly comes up at Boot Camp sessions is "Time." We all have a limited amount of it. We all value it. And we all agree it goes by too quickly. One piece of advice that many veteran dads tell rookies is "Spend time with your child."

Parenting experts and current research support the wisdom of these veterans' advice. Children whose fathers play a consistent, positive role in their lives do better socially, intellectually, emotionally, and

developmentally as children AND as adults, regardless of whether their mothers and fathers are married or living together.

According to David Blankenhorn, author of *Fatherless America* and co-founder of the National Fatherhood Initiative, "Fatherlessness is the most harmful trend of this generation. It is the leading cause of declining child well-being in our society. It is also the engine driving our most urgent social problems, from crime to adolescent pregnancy to child sexual abuse to domestic violence against women."

Many of us have important jobs or careers, but the truth is that any of us can be replaced easily at our workplace. The same is not true in being a dad. Our children have only one father – an exclusive role that cannot be filled if we are absent. We only have so much time to share. Share it with your kids while you can.

Boot Camp is a class for dads with babies and dads expecting babies. For more information, call Bill and Dawn Horan, Boot Camp Coach/Coordinator, at 219-824-0626 or visit the Boot Camp web site: www.newdads.com.



First Steps
Indiana Children's
Special Health Care Services

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Division of Family & Children
Bureau of Child Development
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First Steps
Indiana Children's
Special Health Care Services

KIDSteps Magazine
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Early Intervention System
and the Indiana Children's
Special Health Care
Services Program.

INDIANA KIDSteps MAGAZINE

SUMMER 2001

**SPECIAL
ISSUE ON
OUTCOMES-
BASED
EVALUATIONS**



THIS MAGAZINE'S MISSION

The mission of this quarterly publication is to offer useful information to families, providers, service coordinators, medical professionals, and others who have special interest in the successes and challenges of early intervention and early childhood development in Indiana and neighboring states.

Welcome to KIDSteps Magazine.

Summertime always arrives with a wish list of activities vying for first place attention. While the list never gets any shorter, we should reward our collective selves for the positive difference we are making in the lives of the children, families, and communities we serve.

One success-in-the-making is an improved process of measuring the outcomes of the First Steps services. "Outcomes" by definition are the benefits or changes that individuals or communities experience during or after participating in First Steps activities. Examples of outcomes might include a child's or family's progress related to skills, knowledge, behavior, values, or other attributes. More often than not, we measure by dollars invested and numbers of children being served, but the use of outcomes-based evaluation triggers a shift in thinking to that of quality improvement, not merely registered quantities. Ultimately, outcome measurement better equips us with the information to implement more meaningful, lifelong changes for all children, families, and communities.

Our very special thanks to Michael Conn-Powers and Susan Dixon with the Early Childhood Center, Indiana Institute on Disability and Community at Indiana University-Bloomington for their work in creating outcomes-based evaluation for Indiana First Steps and for so generously contributing the article you will find here.

We also invite you to learn more about CHARGE Syndrome – a unique combination of birth defects that is often misdiagnosed and is still on the less-recognized side of infants and toddlers health. The article here provides a broad overview of CHARGE and its attributes. In addition, it is our privilege to introduce Seth Fielder, a CHARGE Syndrome child who is bravely making magnificent strides in becoming a happy, healthy child. Our thanks to Seth's mother, Nicole, and their service coordinator, Anne Wagner, for their story.

Please read the latest information from ICC and Children's Special HealthCare Services, and join us on our mission to provide quality early intervention services to support improved outcomes for all Indiana children, their families, and communities.

Maureen H. Greer

Maureen Greer
Assistant Deputy Director,
Bureau of Child
Development,
First Steps

INDIANA KIDSteps MAGAZINE

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The Future is not someplace we are going to, but one we are creating.

The paths are not found but made...and the activity of making them changes both the maker and the destination.

MEASURING THE OUTCOMES OF FIRST STEPS

Contributed by Michael Conn-Powers & Susan Dixon
Early Childhood Center, Indiana Institute on Disability and Community
Indiana University-Bloomington

Indiana's First Steps Early Intervention System includes more than 5000 early intervention providers serving approximately 14,000 children and their families each year in ways that reflect family concerns and family choices. An additional number of unique and innovative elements continue to strengthen the quality of First Steps system service, including local system points of entry, service provider matrices for family choice, dedicated service coordinators, and a unified training system.

The Indiana Institute on Disability and Community's Early Childhood Center is adding one more important element to the First Steps system – a statewide evaluation system for assessing First Steps' impact. First Steps has one of the finest data collection systems in the nation, pinpointing the exact number of eligible children receiving services, the child's age when he or she was first identified or when services first commenced, the type and amount of services prescribed and actually used, and where those services were delivered. Through its Unified Training System (a collaboration with the Department of Education), First Steps administrators can identify the number and type of trainings provided, the number of family members and professionals who have participated, and the participants' overall evaluation of the training. Together, this data answers important questions for assessing the development and implementation of a statewide, comprehensive, coordinated service system.

Evaluating the development and implementation of the First Steps service system is important in assuring:

- that a service system is in place
- that it follows both the letter and the spirit of the law
- that children and families in need find and access these services in a timely manner
- that services are provided in a way that reflect the concerns, resources, and priorities of the family along with professional input, and
- that the system is accomplishing targeted outcomes.

THE IMPORTANCE OF OUTCOME-BASED EVALUATION

Assessing the implementation of First Steps is different than assessing the progress of its consumers. The former focuses on the process of First Steps, while the latter addresses its outcomes. Our focus on the outcomes of First Steps is rooted in the findings that Congress presented with Part C of the Individuals with Disabilities Education Act in that there is an urgent and substantial need to:

- enhance the development of infants and toddlers with disabilities, minimizing their potential for developmental delay;
- reduce the educational costs to our society by minimizing the need for special education and related services after infants and toddlers with disabilities reach school age;
- minimize the likelihood of institutionalization of individuals with disabilities and maximize their potential to live independently in society; and
- enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities.

Continued on page 4.

OUTCOMES

Continued from page 3.

The outcomes that children, families, and communities should experience as a result of First Steps are increasingly important. Consumers, state policy makers, and the public need to know if a particular service system funded by their tax dollars is making a meaningful difference in the lives of the people it touches. While we know how many children are receiving how much of which services, we don't know if they are learning the skills that will help them at home, in the community, or in school. We know that families receive information and education about their child, services in their community, and tips for carrying out therapy at home. What we don't know is if families are learning to implement the skills that they need to raise happy, healthy, and competent children. We know that communities receive considerable information about First Steps; but we don't know if child care homes and centers fully welcome and include children with disabilities into their settings.



THE BENEFITS OF MEASURING OUTCOMES

A United Way of America publication, "Measuring Program Outcomes: A Practical Approach" (1996), points out that evaluations in most human service efforts typically assess program inputs, activities, and outputs. Inputs look at the resources that are committed to the system, such as money, staff, and equipment. Activities look at the services, service components, and strategies that make up the system, such as assessment, IFSP development, consultative therapy, and service coordination. Outputs are typically quantitative measures that assess the products of the system's activities, such as the number of children and families served, the number of hours of physical therapy provided, and the number of public awareness materials disseminated. What evaluations typically do not assess are the outcomes or benefits of the system's inputs, activities, and outputs. Outcomes, as defined in this publication, "are benefits or changes for individuals or populations during or after participating in program activities...Outcomes may relate to knowledge, skills, attitudes, values, behavior, condition, or other attributes." (p. 2, 1996)

Traditional evaluations are designed to insure compliance, prevent abuses of the system, and insure some minimum levels of quality. The focus is on system inputs (amount of money being spent), activities (types and amount of therapy being provided), and outputs (the number of initial IFSPs completed within regulated timelines). While these types of evaluations can be important and are legislatively required, their shortcomings reinforce management by compliance, employ minimum standards, do not discriminate between high and low quality practices, and do not identify strategies that lead to improvement in outcomes.

Outcomes-based evaluations focus on the results or benefits of the First Steps system. It helps determine if the children, families, and communities receiving early intervention services are accomplishing the outcomes targeted by First Steps. Adopting an outcomes-based evaluation approach represents a shift in thinking, moving from a focus that only includes minimal compliance to one that also includes quality improvement. It provides the information to help local and state decision makers determine the best use of program resources as well as focus on future outcomes that will represent meaningful, lifelong changes in children, families, and communities.

WHAT OUTCOMES ARE BEING IMPLEMENTED BY FIRST STEPS?

During the past two years, the Early Childhood Center has worked with family members, providers, program administrators, and state decision makers to construct an outcomes-based evaluation system. Last year, a series of 17 regional forums, consisting of more than 300 family members, providers, local agency providers, and First Steps administrators helped identify and prioritize important outcomes that should be a part of the First Steps evaluation system. The process generated a total of 35 unique child, family, and community outcomes.

Working with the State Interagency Coordinating Council (ICC) and one of its task forces, the Early Childhood Center selected nine outcomes from the list of 35 to begin developing a statewide, comprehensive evaluation system for First Steps. The selection process required each outcome to best answer three tests:

1. Is it reasonable to believe that First Steps can influence the outcome in a non-trivial way?
2. Would measurement of the outcome help identify First Steps' successes and help pinpoint and address problems or shortcomings?
3. Will First Steps' stakeholders accept this as a valid outcome of First Steps?

The nine outcomes prioritized by the State ICC and adopted by the State to begin creating a statewide evaluation system are:

1. Children attain essential and important developmental skills.
2. Children participate in inclusive community activities, settings, and routines.
3. Children (and families) are safe, healthy, and well nourished.
4. Families participate as members of the early intervention team and carry out recommendations that help them to help their child.
5. Families are connected to other families and natural community supports for emotional support.

6. Families advocate by exercising their rights in requesting and choosing goals, services, and supports.
7. Communities are informed of and promptly refer families to First Steps.
8. Communities welcome and fully include children with disabilities and their families (e.g., child care, transportation, retail, housing, employment).
9. Communities provide all families access to health care services.

The current draft of the program logic model may be downloaded from the First Steps web site www.state.in.us/fssa/first_step.

WHAT IS INDIANA DOING ABOUT OUTCOMES MEASUREMENT?

Currently, the Early Childhood Center is working with an ICC Task Force to create measurement tools and strategies for assessing the presence of these outcomes in all children, families, and communities served by First Steps. Five surveys have been drafted for possible implementation, yet local, state, and national experts have indicated that this number may need to be reduced for easier use. Three primary survey tools will be used:

1. An initial survey conducted with the family, service coordinator, and initial IFSP team to collect initial assessment information of family and team concerns, resources, and priorities;
2. An exit survey conducted with the family, service coordinators, and current service providers; and
3. A community survey that is distributed periodically.

Once the survey and data collection processes are complete, pilot tests in four Indiana counties will be initiated to help assess the quality of information and implementation. Early Childhood Center staff will provide training and support to promote the statewide implementation of the First Steps evaluation system beginning in 2002.

Data collected through this statewide evaluation system will be used to examine the outcomes that children, families, and communities are achieving at county levels and

throughout the state. The data may also be combined in ways to compare progress across families who have different geographical, economic, and eligibility backgrounds. This evaluation system will NOT be used to review the progress of individual children and families; nor will it be used to review the outcomes associated with individual providers or service agencies. Ultimately, the collected information of system inputs, activities, outputs, and outcomes will enable decision makers to define First Steps' progress and implement efforts that will improve the overall First Steps service system.

REFERENCE

United Way of America (1996). *Measuring Program Outcomes: A Practical Approach*. Alexandria, Virginia. No authors given.



Understanding Children with CHARGE Syndrome

CHARGE Syndrome refers to children with a specific set of birth defects. "CHARGE" originally came from the first letter of some of the most common features seen in these children:

Coloboma, Cranial nerves
Hear defects
Atresia of the choanae
Retardation of growth and development
Genital and urinary abnormalities
Ear abnormalities and/or hearing loss

The diagnosis of **CHARGE** is based on finding several of these and possibly other birth defect features in a child. Every case is unique and can vary from mild to severe.

Other features are associated with CHARGE Syndrome: Children with CHARGE Syndrome may have cleft lip and palate, tracheo-esophageal fistula, or poor immune response. Many have weak upper body strength. There may be some behavior problems associated with CHARGE Syndrome, but not enough information is available at this time.

WHAT THERAPIES AND OUTCOMES ARE AVAILABLE?

Although these children have many problems, they can survive and become healthy, happy citizens. Many of the structural abnormalities can be surgically corrected. In any child in whom CHARGE Syndrome is suspected, complete cardiac (heart), ophthalmological (eye), and audiological (hearing) evaluations should be performed, as well as abdominal ultrasound (kidney), and chromosome evaluation. Appropriate therapies and educational intervention must take into account any hearing and vision loss that is present.

WHAT ARE THE FEATURES OF CHARGE SYNDROME?

Coloboma. A coloboma is a cleft or failure to close of the eyeball. This results in a keyhole-shaped pupil or abnormalities in the retina or optic nerve. Colobomas of the retina or optic nerve may result in significant vision loss, and the visual acuity may also be affected, resulting in nearsightedness or farsightedness. Surgery cannot correct ocular colobomas, but glasses often help with visual acuity. Children with CHARGE Syndrome are often very sensitive to light and are more comfortable with sunglasses, even indoors.

Cranial nerves. About 40 percent of children with CHARGE Syndrome have facial palsy, and at least 30 percent have swallowing problems. Children with facial palsy may be more likely to have sensorineural hearing loss. Swallowing problems often last for years, but typically resolve by age 7 or 8.

Heart. About 80 percent of children with CHARGE Syndrome are born with a heart defect. Many are minor defects, but some require treatment or surgery.

Atresia of the choanae. The choanae are the passages from the back of the nose to the throat that make breathing through the nose possible. In children with CHARGE Syndrome, these passages may be blocked or narrowed. Surgery can often correct these defects.

Retardation of growth and development. Although most children with CHARGE Syndrome are average size at birth, many become small due to nutrition or heart problems, or growth hormone deficiency. Most CHARGE Syndrome children are developmentally delayed, primarily due to sensory deficits (vision and/or hearing loss) and frequent hospitalizations as infants. Some children with CHARGE Syndrome will be mentally retarded, with or without brain abnormalities.

Genital and urinary abnormalities. Many boys with CHARGE Syndrome have a small penis and/or undescended testes. Girls may have small labia. Boys or girls with CHARGE Syndrome may require hormone therapy to achieve puberty. Boys and girls may have kidney or urinary tract abnormalities, especially reflux.

Ear abnormalities and hearing loss. Most children with CHARGE Syndrome have unusual external ears, including short, wide ears with little or no earlobe with a "snipped off" appearance to the outer fold of the ear. The ears may be soft due to floppy cartilage. Hearing loss is present in 80 to 85 percent of children with CHARGE Syndrome, ranging from mild hearing loss to profound deafness. The hearing loss can be difficult to evaluate due to frequent ear infections, presence of other medical conditions, and general difficulty of testing. Many children have additional conductive losses due to frequent ear infections. Many children also have difficulty with balance.

For more information contact the CHARGE Syndrome Foundation, Inc., 2004 Parkade Boulevard, Columbia, MO 65202-3121 or call toll free (800) 442-7604. For online information, log onto the foundation's web site at www.chargesyndrome.org.

The CHARGE Syndrome International Conference convened in Indianapolis July 20 through 22.

Post-conference information will be published in the organization's fall newsletter and online at www.chargesyndrome.org.

**SUPPORT
FOR
SPINA
BIFIDA**

Spina bifida is the most frequently occurring permanently disabling birth defect. It affects approximately one out of every 1,000 newborns in the United States. The Spina Bifida Association of America is a national organization that maintains an updated web site as part of its mission to promote the prevention of spina bifida and to enhance the lives of all affected. The Association represents more than 70 state chapters whose efforts benefit thousands of infants, children, adults, parents and professionals each year.

The Spina Bifida Association of Central Indiana and Northern Indiana provide support to individuals with spina bifida, their families, and caregivers. For more information please contact the local chapter nearest you:

SBA of Central IN
P.O. Box 19814
Indianapolis, IN 46219-0814
TEL: (317) 592-1630
FAX: (317) 577-2568
Email: BernyFitz@aol.com

SBA of Northern Indiana
2421 - DI South Nappanee Street
Elkhart, IN 46517
TEL: (219) 295-3988
Toll Free: 1-866-822-6499

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Indiana State Department of Health

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Dear CSHCS Parent or Guardian:

There will soon be changes in the way that your child's services are authorized for the Children's Special Health Care Services (CSHCS) Program. After June 30, 2001, instead of calling your local care coordinator to have your specialty care services pre-authorized, please call 1/800-475-1355 or the TTY number at 1/866-275-1274 to have all of your specialty care services pre-authorized. In addition, if you need to change your current primary care physician, specialty care physician, or if you have eligibility or billing questions, we again ask that you call the 1/800-475-1355 or the TTY number at 1/866-275-1274.

The CSHCS Program has experienced continued growth of participants as well as increased cost for and utilization of services. For example, in 1995, the CSHCS Program served fewer than 3,000 children; in 2000, the CSHCS Program served more than 10,000 children with the same funding base. The CSHCS Program must become more efficient in providing services in order to maintain your child's current benefit package and health care services. We hope these changes will enable us to avoid any decreases in direct services and benefit to participants.

I would like to clarify that the only services that will be discontinued after June 30, 2001, are local care coordination home visits and services. The health care services that your child receives locally will not be affected by the centralization of care coordination and authorization services, and you will be able to continue to use the same providers.

Enclosed is your new CSHCS participant card. Please review the card and make sure this information is correct as the card serves as documentation of enrollment on the CSHCS Program. Remember to present your participant card at your doctor's office or pharmacy whenever you receive health care services. If you have any questions regarding the participant card or the program in general, please call the CSHCS Program at 1/800-475-1355 or the TTY number at 1/866-275-1274.

The card lists the participant's name, key number, the date the participant became effective on the CSHCS Program, your child's date of birth, billing addresses for providers and the CSHCS 800 number and the TTY number for pre-authorization of services. Again, we ask that you please present the card to your primary, specialty care providers and pharmacy at your next visit to complete their billing.

Also enclosed for your use is a revised and updated participant manual. This revised manual is being issued to help explain the services provided by the Program. It is your responsibility to become familiar with CSHCS policies in order to ensure coverage if you want to be sure a service is covered.

Again, these changes are being made because the CSHCS Program must become more efficient in providing services in order to maintain your child's current benefit package and health care services. On behalf of the CSHCS Program, we look forward to continuing to serve you and your family. Please contact us if you have questions or concerns.

Sincerely,

Wendy S. Gattelfinger

Wendy S. Gattelfinger, R.N., D.N.S., J.D.

Director, CSHCS/WIC

Enclosure

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FAMILY IN THE SPOTLIGHT

The Master of Personality: the magnetic charm of SETH FIELDER

For being just two and a half years in age, Seth Fielder already has mastered the art of capturing attention and hearts. His generously social nature and genuine curiosity

about everyone and everything in his

surroundings make for busy days and restful nights for Seth – no small feat for a little boy struggling against the effects of CHARGE Syndrome.

CHARGE Syndrome is really a compilation of several different, but often related birth defects. As complicated as it may sound, no two CHARGE Syndrome cases are exactly alike. (See "Understanding Children with

CHARGE Syndrome" on page 7). Seth's set of complications was

immediately noted at birth, sending him to the hospital's ICU for six

weeks. A series of specialists examined Seth from head to toe, eventually leading to his diagnosis of CHARGE Syndrome. Seth's specific combination of CHARGE characteristics include coloboma (a cleft or failure to close of the eyeball), cleft lip and palate, a heart murmur, retardation of growth, gastric-intestinal problems, and external ear abnormalities (smaller ears with little or no cartilage).

At one point during his stay in ICU, Seth weighed in at just less than five pounds. Since birth, he has received surgeries to correct his cleft lip, insert a G-tube for feeding, help his breathing by removing his tonsils and excess throat tissue. His cleft palate will be corrected in the future as soon as he grows and gets stronger.

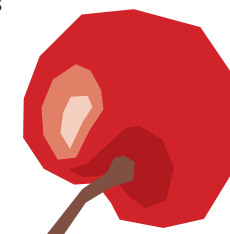
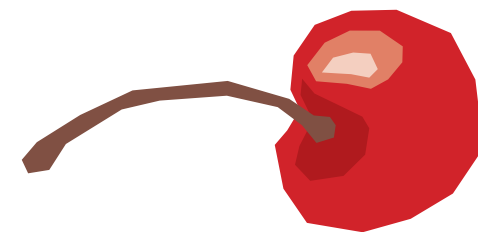
Currently, Seth is about 31 inches tall and only 20 pounds, but don't let his "lightweight" status sway your thinking. His mother, Nicole, and three therapists will tell you that he's all boy all the time. Seth participates in speech, occupational and physical therapy sessions three times each week. He is steadily becoming stronger, and Nicole hopes that he'll be walking before he ages out of First Steps in another six months. His increasing independence is a good sign that he might!

Seth's true strength is in discovering his own potential. Every day, Seth explores a little more to satisfy his curiosity with the world around him. He loves the spotlight almost as much as he loves to play in the water. Bathtubs, play pools, and eventually mud puddles rate high on Seth's list of favorite things.

Nicole gives First Steps and her service coordinator, Anne Wagner, two thumbs up. Fortunately for the Fielders, their physician referred them to First Steps two weeks before Seth was scheduled to leave Elkhart Memorial Hospital. The local intake coordinator helped Nicole understand the First Steps system, and Anne took over from there. "Anne is the best," beams Nicole. "She has helped us so much, through thick and thin. She's a wonderful service coordinator and friend." Seth happens to think so, too. There's no mistake about that when Anne stops for a visit or joins the family for an appointment.

CHARGE Syndrome occurs in approximately 1 per every 10,000 to 12,000 births. While more physicians and hospitals are actively recognizing the linking characteristics of the birth defects, it remains very under-diagnosed. The frequency is the same in males and females, and CHARGE Syndrome crosses all races. The good news is that children who suffer from CHARGE Syndrome can and do grow to be happy, healthy adults.

For Seth, that could mean he'll need an Olympic size pool some day.



"Enhancing the choice of early intervention services for infants and toddlers with special needs and their families through community involvement."



REPORT FROM THE ICC CHAIR

Several ICC task forces have been working in 2001. The ICC Public Awareness Task Force met three times in early 2001 and presented its report to the ICC in May. The goal of this group is to educate the early intervention community about issues affecting young children with special needs. Their tasks to date included:

- Gather information and monitor legislative activity affecting services to children with special needs
- Determine impact of legislation identified
- Volunteer task force members each followed several bills of interest and reported their status at each meeting. Overall, the group reviewed over 60 bills pertaining to young children and chose 36 as the most crucial to early intervention issues. The

task force classified those bills as A (top priority, may need testimony) or B (important but probably just need monitoring rather than comment).

- Provide ongoing reports as necessary and prepare final report to ICC in May 2001

The final report was presented and approved at the May 16 ICC meeting. The ICC Chair communicated to the ICC during the session regarding bills directly impacting the First Steps system. The report included bill summaries with a status notation for each stating the bill's outcome as of May 1, 2001. Anyone who would like a copy of the final report should contact ICC Staff Support Jan Bledsoe at 317-894-0818 or jbledsoe@child-dev.com.

I learn at my own pace.

If you have questions because you think it's taking me a long time to learn to do some items in this list, please call my doctor or nurse, or call the local **First Steps** office. If you don't know the local phone number, call **1-800-441-7837**.

At 13-15 months watch for me to:

- ▶ let you know what I want without crying. I may point, reach, make a sound, put up my arms, pull on you or even say a word.
- ◆ stand for 10 seconds or more.
- wave bye-bye when someone is leaving and says, *bye-bye* to me.
- ◆ call you *mama* and *dada*. You are so happy to hear me say those words when I see you.
- ▶ talk all the time. Most of the time it sounds like jabbering and I am the only one who knows what it means.
- know the meaning of some words like *juice*, *cup*, *on* and *out*.
- ◆ hold up my head without bobbing it around when I sit in your lap.
 - ◆ stoop to pick up something and stand up again without holding on to anything.
 - drop small things like a block into a container. When I do this, I open my hand to drop the block.
 - ◆ turn and look when you call me.



COST PARTICIPATION POLICY DRAFTED

The Bureau of Child Development in partnership with the Governor's Interagency Coordinating Council for Infants and Toddlers, held public forums in May and June seeking input regarding the development of policy related to cost participation. Thirteen forums total were held in Muncie, Evansville, Merrillville, South Bend, Fort Wayne, Indianapolis and New Albany.

A facilitated discussion process was used to gather input regarding family medical expenses and personal care expenses that stakeholders believe deserve consideration in the development of policies and procedures related to cost participation. In addition, participants were asked to give comments regarding the consequences if a family eligible for cost participation fails to pay.

A separate page on the First Steps web site has been established to support timely and accurate communication regarding this issue. A synthesis of each forum discussion is available on the web site. A question and answer document regarding cost participation is also available on the site. The web page will be updated as new information becomes available. The policy draft will be posted for public comment on August 1, 2001, and all interested parties should use that opportunity to review the policy and make comments.

Thanks to the providers, family members, council members and other stakeholders who were able to participate in the forums and give valuable input to the process!

UPCOMING TRAINING OPPORTUNITIES

Indiana First Steps along with Unified Training Systems (UTS) and the Indiana Parent Information Network (IPIN) provide many education and training opportunities for parents and providers throughout the year. Please check out the Events Calendar for Indiana's Early Childhood Community at :

<http://earlychildhoodmeetingplace.indiana.edu>

or

<http://www.iidc.indiana.edu/~ecc/uts/uts.html>

FIRST STEPS PROGRAMMATIC TRAINING:

Orientation to First Steps

- Service Coordination—Level 1
- Service Coordination—Level 2

Topical Issues:

- Infant Mental Health
- Advanced Practice of OT/PT
- Advanced Practice for OT/PT/SLP
- Advanced Practice for Cerebral Palsy
- Communication Methodologies Related to Hearing Loss

- Developmental Intervention for High Risk Newborns
- Advanced Feeding Issues
- Developmental Therapy Series
- LPCC Leadership Conference

IPIN Training:

- Health Care Financing
- Financial Case Management
 - Private Health Insurance
 - Public Health Insurance, i.e. Medicaid/Medicaid Waiver
- Article 7 Special Education Rights
- Parent Liaison Training

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